MDR: M4-02-4889-01

THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER: SOAH DOCKET NO. 453-03-2382.M4

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be reimbursement of $1,585.00 for dates of service, 10/01/01, 10/02/01, 10/03/01, 10/04/01, 10/15/01, 10/17/01, 10/18/01, 10/19/01.

   b. The request was received on 08/05/02.

II. EXHIBITS

1. Requestor, Exhibit I:

   a. TWCC 60 and Letter Requesting Dispute Resolution
   b. HCFA(s)
   c. EOB/TWCC 62 forms/Medical Audit summary
   d. Medical Records
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:

   a. TWCC 60 and Response to a Request for Dispute Resolution
   b. Medical Audit summary/EOB/TWCC 62 form
   c. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 09/09/02. Per Rule 133.307 (g) (4) or (5), the carrier representative signed for the copy on 09/09/02. The response from the insurance carrier was received in the Division on 09/23/02. Based on 133.307 (i) the insurance carrier's response is timely.

4. Notice of Additional Information submitted by Requestor is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Letter dated 07/31/02

   "The information listed in this denial would again be found in the same documentation previously listed in this letter, as the treatment provided was clearly outlined in the progress summaries, flow sheets, and daily notes submitted previously with these claims. The carrier had merely to review the accompanying documentation when reviewing these claims to verify that the required elements were present. However, the carrier for what seems to be invalid reasons denied these claims… (Requestor) provided effective, highly efficient and successful treatment within all parameters established by TWCC guidelines and therefore, full payment for these claims is warranted."

2. Respondent: Letter dated 09/23/02

   "In review of the additional documentation, the (Carrier) contends that the requestor's documentation submitted to support services billed does not meet the criteria set under Rule 133.1 (a) (3) (E) (1). The rule states that for the three highest level office visits, single and interdisciplinary programs such as work conditioning programs, work hardening programs and physical medicine treatment(s) and/or services shall substantiate the care given and the need for the further treatment(s) and/or services and indicate progress, improvement, the date of the next treatment(s) and /or services, complications, and expected release dates. Therefore, based on the rationale set out by the Act and Rules, the (Carrier) will maintain our position that the documentation submitted by the requestor does not support the services billed."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only dates of service eligible for review are 10/01/01, 10/02/01, 10/03/01, 10/04/01, 10/15/01, 10/17/01, 10/18/01, and 10/19/01.

2. This decision is being written based on the documentation that was in the file at the time it was assigned to this Medical Dispute Resolution Officer.

3. Per the Requestor's Table of Disputed Services, the Requestor billed the Carrier $1,585.00 for services rendered on the above dates in dispute.

4. Per the Requestor's Table of Disputed Services, the Carrier paid the Requestor $0.00 for services rendered on the above dates in dispute.

5. Per the Requestor's Table of Disputed Services, the amount in dispute is $1,585.00 for services rendered on the above dates in dispute.

6. The Carrier's EOB deny reimbursement as "N72 Not Documented. Documentation must include treatment provided (with days of week), response to treatment, progressive

overall improvement of symptoms; failure to respond to treatment should reflect a change of the treatment plan."

7. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	BILLED	PAID	EOB Denial Code(s)	MAR$	REFERENCE	RATIONALE:
10/01/01 10/01/01 10/01/01 10/01/01 10/02/01 10/02/01 10/02/01 10/02/01 10/03/01 10/03/01 10/03/01 10/03/01 10/04/01 10/04/01 10/04/01 10/04/01 10/15/01 10/15/01 10/15/01 10/17/01 10/17/01 10/17/01 10/18/01 10/18/01 10/18/01 10/18/01 10/19/01 10/19/01 10/19/01	97112 97113 97150 97110 97112 97113 97150 97110 97112 97113 97150 97110 97112 97113 97150 97110 97112 97150 97110 97112 97150 97110 97112 97113 97150 97110 97112 97150 97110	$35.00 $52.00 $27.00 $105.00 $35.00 $52.00 $27.00 $105.00 $35.00 $52.00 $27.00 $105.00 $35.00 $52.00 $27.00 $105.00 $35.00 $27.00 $70.00 $35.00 $27.00 $70.00 $35.00 $52.00 $27.00 $70.00 $35.00 $27.00 $70.00	$0.00 $0.00 $0.00 $0.00 $0.00 $0.00 $0.00 $0.00 $0.00 $0.00 $0.00 $0.00 $0.00 $0.00 $0.00 $0.00 $0.00 $0.00 $0.00 $0.00 $0.00 $0.00 $0.00 $0.00 $0.00 $0.00 $0.00 $0.00 $0.00	N72 for all dates	$35.00/15 mins $52.00/15 mins $27.00 $35.00/15 mins	MFG; MGR (I) (A) (9) (b); (C) (9); CPT Descriptor	Recent review of disputes involving one on one CPT Codes, 97112 and 97113, by the Medical Dispute Resolution section indicate overall deficiencies in the adequacy of the documentation of this Code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one." Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division has reviewed the matters in light all of the Commission requirements for proper documentation. The therapy notes for these dates of service does not support any clinical (mental or physical) reason as to why the patient could not have performed these exercises in a group setting, with supervision, as opposed to one-to-one therapy. Additionally, the MFG states, "If any of the procedures (97110-97139) are performed with two or more individuals, then 97150 is reported. Do not code the specific type of therapy in addition to the group therapy." The Requestor has billed for CPT Code 97150 but has not provided documentation of what therapy is being administered to the claimant. **No** additional reimbursement is recommended.
10/15/01 10/17/01 10/19/01	97250 97250 97250	$43.00 $43.00 $43.00	$0.00 $0.00 $0.00	N72	$43.00	MFG MGR (I) (A); CPT Descriptor	The provider has billed for CPT Code 97250, myofascial release. Pursuant to the MFG "The treatment plan shall contain the following: a. type of intervention/treatment modality; b. frequency of treatment' c. expected duration of treatment; d. expected clinical response to treatment; and e. specification of a re-evaluation timeframe." . The provider has not submitted the information to support the documentation requirements for reimbursement. Therefore, no reimbursement is recommended.
Totals		$1585.00	$0.00				The Requestor **is not** entitled to reimbursement.

The above Findings and Decision are hereby issued this 8th day of January 2003.

Denise Terry
Medical Dispute Resolution Officer
Medical Review Division
DT/dt